**956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY**

956 CMR 12.00: ELIGIBILTY, ENROLLMENT AND HEARING PROCESS FOR CONNECTORCARE

Section



12.01: Purpose

The purpose of 956 CMR 12.00 is to implement the provisions of M.G.L. ch. 176Q and thereby facilitate the availability, choice and adoption of qualified health plans to eligible individuals, families and groups.

12.02: Scope

956 CMR 12.00 contains the Connector's regulations governing eligibility for ConnectorCare, enrollment, responsibility of Enrollees, Enrollee premium contributions, disenrollment and the related appeal process under M.G.L. ch. 176Q. The Connector also promulgates other regulations, and publishes other documents affecting its programs, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, administrative information bulletins and other documents as necessary.

12.03: Definitions

As used in 956 CMR 12.00, the following terms shall mean:

Abuse. Physical or verbal abuse which poses a threat to health care providers or other insureds of the Health Plan and which is unrelated to the Enrollee's physical or mental condition.

Adverse Eligibility Determination. A determination that an applicant is not eligible to participate in ConnectorCare or a determination that an Enrollee is no longer eligible to participate in ConnectorCare.

Appeal Representative. A person who:

(a) is sufficiently aware of an appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has been provided with written authorization from the appellant to act on the appellant's behalf during the appeal process;

(b) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney or health care proxy.

Appealable Action. Any of the actions listed in 956 CMR 12.12.

Applicant. A person who completes and submits an application for ConnectorCare.

Application. A form prescribed by the Connector to be completed by the applicant or a representative, and submitted to the Connector or its designee as a request for a determination that the Applicant is eligible for enrollment in ConnectorCare.

Board. The Board of the Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q, §2.

Commonwealth. The Commonwealth of Massachusetts.

Commonwealth Health Insurance Connector Authority or Connector or Authority. The entity established pursuant to M.G.L. c. 176Q, § 2.

ConnectorCare. The program administered by the Authority pursuant to M.G.L. c. 176Q to provide premium assistance payments and point-of-service cost-sharing subsidies to Eligible Individuals enrolled in Health Plans.

ConnectorCare Rules and Regulations. All regulations, bulletins and other written directives duly adopted or issued by the Connector relating to the ConnectorCare program.

Co-payment. A type of point-of-service cost-sharing including a fixed amount paid by an Enrollee for applicable services or for prescription medications at the time they are provided.

Covered Services. The range of medical services required to be provided by a Health Plan under ConnectorCare.

Day. A calendar day unless a business day is specified.

Eligibility Determination. A determination that an applicant is eligible or not eligible to participate in ConnectorCare.

Eligible Individual. An individual who is a resident of the Commonwealth and who is eligible to participate in ConnectorCare in accordance with M.G.L. c. 176Q and 956 CMR 12.08.

Enrollee. An Eligible Individual enrolled by the Connector or its designee in a Health Plan.

Enrollment. The selection of a Health Plan.

Enrollment Effective Date. The first day of the calendar month following the completion of the Enrollment Process except in the case of birth, adoption or placement for adoption or foster care, the Enrollment Effective Date is the date of the birth, adoption or placement for adoption or foster care.

Enrollment Process. The process in which an Eligible Individual chooses a Health Plan and pays any applicable Enrollee Premium Contribution.

Family. A single household for purposes of eligibility for ConnectorCare as defined in 26 CFR 1.36B-1(d).

Federal Advance Premium Tax Credit. Payment made pursuant to 26 U.S.C. § 36B on behalf of an eligible individual to reduce the value of a health benefit plan premium.

Federal Poverty Level (FPL). The income standard, by such name, issued annually in the *Federal Register*, as adjusted to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fraud. An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the ConnectorCare program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or state health care fraud laws. Examples of Enrollee fraud include, but are not limited to: improperly obtaining prescriptions for controlled substances and card sharing.

Health Care Provider. A facility or health care professional, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with the law.

Health Plan. Any managed care organization or carrier that is contracted with the Connector to provide covered services to ConnectorCare Enrollees.

Hearing. An administrative, adjudicatory proceeding pursuant to 801 CMR 1.02 and 45 CFR § 155.500 et seq. to determine the legal rights, duties, benefits or privileges of Applicants (in certain, limited circumstances) and Enrollees pertaining to enrollment; disenrollments of Enrollees; Enrollee Premium Contributions; and denials of waiver requests.

Modified Adjusted Gross Income (MAGI). Income for eligibility determination as defined in the Internal Revenue Code at 26 U.S.C. § 36B(d)(2)(B).

Plan Type. A type of coverage for Enrollees with income within a certain range.

Point-of-service cost-sharing subsidy. A payment made to a Health Plan by the Connector to reduce point-of-service cost-sharing expenses of an individual which shall include, but not be limited to, co-payments, co-insurance and deductibles.

Premium Assistance Payment. A periodic payment made to a Health Plan by the Commonwealth or the Connector on behalf of an Enrollee to reduce the value of a health plan premium paid by the individual.

Premium Contribution or Enrollee Premium Contribution. An Enrollee's actual required periodic financial contribution for coverage under ConnectorCare, determined in accordance with applicable regulations of the Connector, paid to the Connector.

Resident. For an individual who is age 21 and over, a resident is a person who is not living in an institution as defined in 42 CFR 435.403(b), is capable of indicating intent, and is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), the person is a resident if the person is living and intends to reside, including without a fixed address; or has entered with a job commitment or is seeking employment (whether or not currently employed). For an individual who is under the age of 21, a resident is a person who is not living in an institution as defined in 42 CFR 435.403(b), is not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act as addressed in 42 CFR 435.403(g), is not emancipated, is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), the person is a resident if the person resides in Massachusetts, including without a fixed address; or the person's parent or caretaker with whom the individual resides is a resident of Massachusetts.

Service Areas. The Authority's grouping of the cities and towns within the Commonwealth into distinct areas for Health Plans participating in ConnectorCare, as established by contract with the Contracted carrier or managed care organization.

12.04: Eligibility for ConnectorCare

(1) To be eligible for ConnectorCare, the eligibility determination includes a determination of both:

(a) whether, based on family MAGI, the individual is financially eligible for ConnectorCare; and

(b) whether the individual meets other eligibility requirements, including eligibility for federal advance premium tax credits, as set forth in 45 CFR § 155.305(f) and as determined by the Connector.

(2) The financial eligibility for various ConnectorCare Plan Types is determined by comparing the family's MAGI with the applicable income standard for the specific Plan Type in accordance with 12.04(3).

(3) Included in the financial eligibility determination will be a determination of the Plan Type to which an Eligible Individual should belong based on family MAGI. Covered Services, Premium Contributions and Co-Payments will vary among Plan Types, as determined by the Board. The following are the different levels of such income for each Plan Type:

(a) Plan Type I- not in excess of 100% of Federal Poverty Level.

(b) Plan Type II- more than 100% but not in excess of 200% of Federal Poverty Level, except that persons at or below 150% of Federal Poverty Level will be in Plan Type IIA, and those over 150% and not over 200% of Federal Poverty Level will be in Plan Type IIB.

(c) Plan Type III - more than 200% but not in excess of 300% of Federal Poverty Level, except that persons at or below 250% of Federal Poverty Level will be in Plan Type IIIA, and those over 250% and not over 300% of Federal Poverty Level will be in Plan Type IIIB.

12.05: Matching Information

The Connector or its designee initiates information matches with other state and federal agencies and information sources when an Application is received, when eligibility is redetermined, or at other times in the Connector's administrative processes in order to verify eligibility or certain information. These agencies and information sources may include, but are not limited to, the following: the Division of Unemployment Assistance, MassHealth, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Homeland Security, Department of Transitional Assistance and health insurance carriers.

12.06: Standards for an Eligibility Application

In making an eligibility determination for ConnectorCare, the Connector will require an Applicant to complete an Application and provide the information requested in that Application. Based on the information supplied in that Application, additional information may be requested to determine eligibility status.

12.07: Eligibility Review

(1) The Connector or its designee may review eligibility every 12 months. Eligibility may also be reviewed more frequently as a result of an Enrollee's change in circumstances, or a change in ConnectorCare eligibility rules. The Connector or its designee updates the case file based on information received as the result of such review. The Connector reviews eligibility:

(a) by information matching with other state and federal agencies, health plans, and information sources as set forth in 956 CMR 12.05;
(b) through an update of the Enrollee's circumstances; and
(c) based on information in the Enrollee's case file.

(2) The Connector determines, as a result of this review, if:

(a) the Enrollee continues to be eligible for ConnectorCare; or
(b) the Enrollee's current circumstances require a change in Plan Type or Premium Contribution.

(3) The Connector or its designee will notify the Enrollee if there is a change in Plan Type or Premium Contribution, or a change in Enrollee's eligibility.

(4) In the event of a determination that the Enrollee is no longer eligible, the Enrollee will be sent a notice of termination at least 35 days before the termination occurs.

12.08: Eligibility Requirements

(1) An individual who is a resident of the Commonwealth shall be eligible to participate in ConnectorCare in accordance with M.G.L. c. 176Q if:

(a) a family's MAGI does not exceed 300% of the Federal Poverty Level; and
(b) the individual is eligible for federal advance premium tax credits, as set forth in 45 CFR § 155.305(f);

12.09: Responsibilities of Applicants and Enrollees

(1) Responsibility to Cooperate. The Applicant or Enrollee must cooperate with the Connector or its designee in providing information necessary to establish and maintain eligibility and to bill and collect Enrollee Premium Contributions, and must comply with all the rules and regulations of the Connector or its designee. An Applicant's failure to provide information requested during the eligibility determination process may result in a delay in the eligibility determination, or a denial of eligibility.

(2) Responsibility to Report Changes. The Applicant or Enrollee must report to the Connector or its designee, within sixty days or as soon as possible, changes that may affect eligibility or Enrollee Premium Contributions. Such changes include, but are not limited to, residency, address, income, employment, the availability of health insurance, and third-party liability.

(3) Third Party Liability. If an Enrollee is involved in an accident or suffers an injury in some manner and subsequently receives money from a third party as a result of that accident or injury, the Enrollee's then-current Health Plan may have a right to recover some or all of those funds to repay the then-current Health Plan for certain medical services provided to the Enrollee by the Health Plan. In the event that the Health Plan intends to recover any funds from an Enrollee, the Health Plan will provide notice to the Enrollee of any obligation to pay funds back.

12.10: Enrollment, Open Enrollment and Special Enrollment Periods, and Disenrollment

(1) Enrollment. Following a determination of eligibility, Eligible Individuals will be instructed to enroll in a Health Plan. Eligible Individuals will be permitted to choose a Health Plan from among those that operate in their Service Area. Eligible Individuals who are required to pay a premium must pay the first month's premium on or before a due date set by the Connector in order to complete the enrollment process. In the event that a Health Plan ceases operation in a Service Area, the Connector shall notify the Eligible Individuals and permit such Eligible Individuals to choose from among the Health Plans that operate in their Service Area.

(2) Enrollment Effective Date. Eligible Individuals must complete the Enrollment Process in order to receive Covered Services. Coverage will begin on the Enrollment Effective Date, which is the first date of the month following the completion of Enrollment except in the case of birth, adoption or placement for adoption or foster care, the Enrollment Effective Date is the date of the birth, adoption or placement for adoption or foster care.

(3) Premium Contributions. Premium Contributions paid by Enrollees within the same Plan Type may vary depending on the Health Plan selected. The differentials in Premium Contributions for Health Plans will be determined by the Connector based on the difference in cost of the Health Plans. There will be at least one Health Plan available to Plan Type I and Plan Type IIA members that has no Premium Contribution provided that the Enrollee chooses to elect the full amount of federal advance

premium tax credits available to that Enrollee. There will be at least one Health Plan available to Plan Types IIB and III members that will cost the minimum Premium Contribution set by the Board in accordance with 956 CMR 12.11(8) provided that the Enrollee chooses to elect the full amount of federal advance premium tax credits available to that Enrollee.

(4) Notification. The Connector will notify an Enrollee in writing of the name and address of the Enrollee's Health Plan and Enrollment Effective Date.

(5) Open Enrollment and Special Enrollment Periods. The Enrollee may enroll in a Health Plan in that Enrollee's Service Area during any open enrollment periods established by state or federal law. Enrollees may transfer from a Health Plan or enroll in a Health Plan outside of the open enrollment period during a special enrollment period established by the Connector only for one of the following reasons:
(a) the Enrollee experiences a triggering event, as set forth in 45 CFR § 155.420 and applicable state law;
(b) a qualified individual is determined newly eligible for a ConnectorCare plan in accordance with 956 CMR 12.08;
(c) the Enrollee changes Plan Types in accordance with 956 CMR 12.04(3);
(d) the Enrollee has been approved for a hardship waiver in accordance with 956 CMR 12.11; or
(e) the Enrollee's hardship waiver period has ended.

Enrollees will have sixty (60) days to enroll in a Health Plan from the date of one of the events described above.

(6) Disenrollment of Enrollees. The Connector may disenroll or terminate an Enrollee in accordance with any applicable grace periods as set forth in state and federal law, including, but not limited to the following reasons:

(a) upon request of the Health Plan, if the Health Plan has established that the Enrollee has committed Fraud or Abuse;
(b) for failure to pay Enrollee Premium Contribution payments under 956 CMR 12.11;
(c) for Fraud or Abuse;
(d) when the Enrollee is no longer eligible for coverage;
(e) If the Connector disenrolls an Enrollee pursuant to 956 CMR 12.10(6), it will provide the enrollee with written notice stating the reason for the action.
(f) The Connector may recoup any monies paid on behalf of an Enrollee to a Health Plan or a health care provider from the Enrollee directly if it is determined that the Enrollee committed fraud.

12.11: Enrollee Premium Contributions

(1) Enrollee Premium Contribution Payments. Enrollees who are assessed an Enrollee Premium Contribution are responsible for monthly payments that must be paid on or before a due date set by the Connector. The Connector will establish and maintain at least one convenient payment method for Enrollees.

(2) Delinquent Enrollee Premium Contribution Payments. An Enrollee who fails to pay his/her monthly Enrollee Premium Contribution Payment in full by the payment due date will be considered delinquent and may be notified on the day following the payment due date when his/her account is one month past

due. If payment is not received by the second month, the Enrollee will again be delinquent and notified on the day following the payment due date when his/her account is two months past due. This Notice of Delinquency will inform the Enrollee that, if payment of the outstanding monthly contribution is not received in full on or before the payment due date indicated in the Notice, then the coverage will be terminated retroactively to the last day of the first coverage month in which the Enrollee was delinquent.

(3) Disenrollment for Failure to Pay Enrollee Premium Contribution Payments. If a delinquent Enrollee has not paid his/her outstanding Enrollee Premium Contribution Payments in full by the due date indicated in the Notice of Delinquency, then the coverage is terminated on the day following that date. Coverage end date is retroactive to the last day of the first coverage month in which the Enrollee was delinquent. The Enrollee is notified of the termination by mail or electronically with a Notice of Termination.

(4) Reinstating Coverage Following Disenrollment. An Enrollee who was terminated for non-payment of premiums may reinstate coverage within thirty (30) days from the date coverage was terminated. All outstanding monthly contributions must be paid in full as well as the next month's contribution.

(5) Waiver or Reduction of Enrollee Premium Contribution for Extreme Financial Hardship.

(a) Extreme financial hardship means that the Enrollee has shown to the satisfaction of the Connector that the Enrollee:

1. is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received an eviction or foreclosure notice within the last sixty (60) days; or
2. has a shut-off notice, or has been shut off, or has a refusal to deliver essential utilities within the sixty (60) days prior to application (gas, electric, oil, water, or sole telephone); or
3. has incurred a significant, unexpected increase in essential expenses within the last six months resulting directly from the consequences of:
    a. domestic violence;
    b. the death of a spouse, family member, or partner with primary responsibility for child care;
    c. the sudden need to provide full-time care for self, for an aging parent or for another family member, including a major, extended illness of a child that requires a working parent to hire a full-time caretaker for the child; or
    d. a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the Enrollee; or
4. has filed for bankruptcy within the last twelve (12) months as long as the debts have not yet been discharged.

(b) If the Connector determines that the requirement to pay an Enrollee Premium Contribution or arrears results in extreme financial hardship for the Enrollee, the Connector may waive payment of such Contribution or arrears; or reduce the amount of such Contribution or arrears assessed to a particular individual. The Connector will assume payment to the Health Plan of the amount of the Enrollee's premium contribution that is waived or reduced during the waiver period.

(c) An Applicant who has been found eligible for ConnectorCare may request a premium waiver prior to enrollment, although the filing of such request does not entitle such Applicant to enroll while the request is pending.

(d) Waivers or reduction of premium will be authorized for up to 11 months. The waiver or reduction period begins on the first of the month of the next full billing cycle following the date the waiver or reduction of premium is granted. An Enrollee who is granted a waiver or reduction

will be allowed to enroll in a Health Plan available in that Enrollee's Service Area. At the end of the waiver or reduction period, the Enrollee may submit another request if the extreme financial hardship persists. Requests for Enrollee Premium Contribution relief should be addressed to the Connector.

(e) Enrollees who have been approved for a waiver or reduction of premium or whose waiver or reduction period has ended may transfer to a different Health Plan within sixty (60) days.

(6) Voluntary Withdrawal. If an Enrollee wishes to voluntarily withdraw from receiving ConnectorCare, it is the Enrollee's responsibility to notify the Connector of his or her intention by phone or, preferably, in writing. Coverage continues through the end of the calendar month of withdrawal. The Enrollee is responsible for the payment of all Enrollee Premium Contributions up to and including the calendar month of withdrawal.

(7) Change in Enrollee Premium Contribution Calculation. The Enrollee Premium Contribution amount is recalculated when the Connector is informed of changes in income, family size, or health-insurance status, and may be changed whenever the cost to the Connector of contracting with a Health Plan changes or as a result of a change in a Health Plan's Service Area.

(8) Minimum Monthly Enrollee Premium Contribution Schedule. The Board shall determine annually the minimum monthly Premium Contributions for each Plan Type. The Premium Contributions shall be set forth in a schedule that will be published annually.

(9) Monthly ConnectorCare Premium Assistance Payments. Premium Assistance Payments will be paid by the Connector monthly from funds appropriated by the Commonwealth for the purpose, or otherwise made available to the Connector together with the Enrollee Premium Contributions received by the Connector, to pay the premiums due to the Contracted Health Plan.

(10) Termination of Health Insurance. If an Enrollee's ConnectorCare terminates for any reason, beginning the first day of the following month the Enrollee Premium Contributions and the allocable ConnectorCare Premium Assistance Payments and Point-of-service cost-sharing subsidies end.

12.12: Right to a Hearing

Applicants and Enrollees are entitled to a hearing to appeal the following actions:
(1) any adverse eligibility decision based on any eligibility factor in accordance with 956 CMR 12.08;
(2) any calculation of the premium assistance payment amount or assignment to a Plan Type; or
(3) the Connector's denial of a financial hardship waiver or reduction of premium or renewal of a financial hardship waiver or reduction of premium under 956 CMR 12.11.

12.13: Times and Methods for Filing Requests for Hearings

(1) The Applicant or Enrollee will receive a notice in writing of an Appealable Action identified in 956 CMR 12.12 from either MassHealth or the Connector or both. That notice will also include notice of the right to a hearing with the appropriate hearings office, of the method by which a hearing may be requested, and of the right to use an Appeal Representative. The notice will also include a form for appealing the action.

(2) The request for an appeal must be received within the following time limits:

(a) 30 days after the receipt of the notice of the Appealable Action. (In the absence of evidence to the contrary, it will be presumed that the notice was received on the fifth day after mailing.); or

(b) 120 days from the date of an Appealable Action if the MassHealth agency or the Connector fails to send written notice of such action or fails to act on a request for an eligibility determination.

(3) The time periods in 956 CMR 12.13(2) will expire on the last day of such periods unless the day falls on a Saturday, Sunday, or legal holiday, in which event the last day of the time period will be deemed to be the following business day.

(4) Upon request by an Applicant or Enrollee, the Connector will provide the Applicant or Enrollee with a form to bring an appeal. The Connector and or its agent/designee may not restrict the Applicant's or Enrollee's freedom to request a hearing.

12.14: Appeal from Health Plan Actions

Any inquiries, complaints or grievances by an Enrollee against a Health Plan, or any appeal by an Enrollee from an adverse determination by a Health Plan shall be subject to the review and appeal procedures contained in M.G.L. 176O, including appeals to the Office of Patient Protection within the Health Policy Commission, as set forth in 958 CMR 3.00.

12.15: Hearings

(1) Hearings conducted by the Connector will use the policies and procedures for informal hearings set forth in 801 CMR 1.02, as well as the procedures set forth in 956 CMR 12.00 or in any administrative bulletins issued by the Connector.

(2) The Connector may dismiss any request for hearing if:

(a) it is not received within the time periods specified in 956 CMR 12.13;

(b) it does not state a valid ground for appeal under 956 CMR 12.12;

(c) the appeal is withdrawn by the Appellant or Appeal Representative; or

(d) for any reason stated in 801 CMR 1.02.

(3) The Connector may designate a hearing officer to hear any appeals. The hearing officer may, at the request of a party or on his or her own initiative, order that the hearing be conducted by telephone.

(4) The decision of the hearing officer designated by the Connector will be final, except that within 14 days of the issuance of the hearing officer's decision, the Director of the Appeals Unit for the Connector, or his designee, may, for good cause, and at the request of the appealing party or on his or her own initiative, order a re-hearing. In the event that the Director or the Director's designee orders a re-hearing, the Director will give notice in writing to all parties of the date, time, and location of the re-hearing. The re-hearing will be conducted before the Director or another hearing officer whom he designates. Within 30 days after the order requiring re-hearing, the Director or designated hearing officer will conduct the re-hearing and will either issue a superseding decision or decide not to issue a superseding decision. A request for re-hearing stays the initial decision of the hearing officer, and that initial decision will not be deemed final for purposes of the filing of an action for judicial review under

G.L. c. 30A, § 14, until the Director or his designee issues a superseding decision or decides not to supersede the initial decision.

(5) Enrollees who have brought an appeal must continue to pay all required Enrollee Premium Contributions during the pendency of the appeal. Persons who are appealing a denial of a premium waiver or reduction application must pay Enrollee Premium Contributions while the appeal is pending.

12.16: Administrative Information Bulletins

(1) The Connector may issue administrative information bulletins that set out policies that are consistent with the substantive provisions of 956 CMR 12.00. In addition, the Connector may issue administrative information bulletins, which specify the information and documentation necessary to implement 956 CMR 12.00. The Connector may also issue administrative bulletins containing interpretations of 956 CMR 12.00 and other information to assist persons subject to 956 CMR 12.00 meet their obligations under 956 CMR 12.00.

(2) Health Plans, Providers, and Eligible Individuals should refer to the ConnectorCare Rules and Regulations, and other documents published affecting these plans and programs for more detailed information and guidance, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins, Health Plan bulletins and other documents as necessary.

12.17: Severability of Provisions

The provisions of 956 CMR 12.00 are hereby declared to be severable. If any such provisions or the application of such provisions or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 12.00 or the applications of such provisions or circumstances other than those held invalid.

REGULATORY AUTHORITY:

956 CMR 12.00: M.G.L. ch. 176Q.